Uganda

The following provides a summary of specific guidelines from the country's national guidance strategy. Use the jump links in yellow to access details by patient population. This summary can be downloaded or e-mailed to yourself or a colleague. The original country guidance document can also be found below the jump links for download.

Patient Population **Download summary page as PDF** **E-mail this page**
Suggest Updates

- Adults
- Pregnant Women
- Children

Adults

Year Issued:

2013; 2011

Reference:

Addendum To The Antiretroviral Treatment Guidelines For Uganda; The Integrated National Guidelines on Antiretroviral Therapy, Prevention of Mother to Child Transmission of HIV and Infant & Young Child Feeding

Screening for PLHIV for TB Every Visit? (Y/N) (Intensified Case Finding):

Yes (2011 Guidelines)

Criteria for Starting TB Prophylaxis Among TB-Exposed PLHIV:

None indicated

Criteria for Starting TB Prophylaxis Among Unknown TB-Exposed PLHIV:

None indicated

Criteria for Starting: ARV 1st Line Regimen:

Adults (2011)

All HIV-infected patients with diagnosed active TB should be treated with antiretroviral therapy (ART).

1. All TB patients co-infected with HIV should be offered ART irrespective of CD4 cell count no later than 8 weeks and within 2 weeks of starting TB treatment among those with advanced immune suppression (CD4 <50).
2. In HIV infected patients with TB meningitis, ART should be deferred until 2 months after initiation of

TB treatment.

(Addendum: 2013)

Very sick with Pulmonary TB or extra pulmonary TB or WHO stage IV

Irrespective of CD4 cell count

- Start TB therapy and when stable (usually within 2 to 8 weeks)

ADD one of these regimens:

- TDF/3TC/EFV (alternative AZT/3TC/EFV) – not to be used in first trimester of pregnancy or in women of childbearing potential without assured contraception
- TDF/3TC/NVP, AZT/3TC/NVP, - used only if in rifampicin-free continuation phase

Pulmonary TB:

- Clinically stable
- CD4 >350/mm3

Start TB therapy for 2 months THEN start one of these regimens:

- TDF/3TC/EFV or NVP
- AZT/3TC/EFV or NVP

Develops TB when already on ART:

- Consider IRIS
- Consider ART failure

Add TB drugs and continue with ART but:

- Change NVP for EFV (except in first trimester of pregnancy)
- Or Use AZT+3TC+ABC Evaluate/assess for ART failure

Tuberculosis and ART failure:

- Falling CD4 count
- Development of other OIsContinue with failing 1st regime until end of Rifampicin – then: Change to 2nd line with PI

ARV 2nd Line Regimen:

Second line ART for patients with TB

There are significant drug interactions with PIs and rifampicin. Rifampicin lowers the blood levels of PIs and vice versa resulting in suboptimal effectiveness. The use of any current PIs with Rifampicin should be avoided. When available, Rifabutin may be used in place of Rifampicin, although it is more costly. (2011)

Pregnant Women

Year Issued:

2011

Reference:

The Integrated National Guidelines on Antiretroviral Therapy, Prevention of Mother to Child Transmission of

HIV and Infant & Young Child Feeding

Screening for PLHIV for TB Every Visit? (Y/N) (Intensified Case Finding):

Yes (2011 Guidelines)

Criteria for Starting TB Prophylaxis Among TB-Exposed PLHIV:

None indicated

Criteria for Starting TB Prophylaxis Among Unknown TB-Exposed PLHIV:

None indicated

Criteria for Starting: ARV 1st Line Regimen:

In all HIV-infected pregnant women with active TB, ART should be started as early as feasible, both for maternal health and for prevention of mother-to-child transmission (PMTCT) of HIV (2013)

CD4 ≤ 350:

- TDF/3TC (alternative AZT/3TC) + NVP (or EFV after 1st trimester)

CD4 ≥ 350:

- TDF/3TC + EFV after 1st trimester

HIV-TB Co-infection:

- Women with TB co-infection on rifampicin, will not take NVP or any PIs (ATV or LPV) containing regimen (2011)

Children

Year Issued:

2011

Reference:

The Integrated National Guidelines on Antiretroviral Therapy, Prevention of Mother to Child Transmission of HIV and Infant & Young Child Feeding

Screening for PLHIV for TB Every Visit? (Y/N) (Intensified Case Finding):

Yes (2011 Guidelines)

Criteria for Starting TB Prophylaxis Among TB-Exposed PLHIV:

All HIV-infected infants and children exposed to TB through household contacts, but with no evidence of active disease irrespective of age

IPT should be given for 6 months and the recommended dose of Isoniazid 10mg/kg (Max of 300 mg daily).

Criteria for Starting TB Prophylaxis Among Unknown TB-Exposed PLHIV:

Children living with HIV (>12 months of age and including those previously treated for TB), who are not likely to have active TB and are not known to be exposed to TB, should receive 6 months of IPT as part of a comprehensive package of HIV care.

Infants living with HIV, who are unlikely to have active TB and are not known to be exposed to TB, should not receive IPT as part of a comprehensive package of HIV care. IPT should be given for 6 months and the recommended dose of Isoniazid 10mg/kg (Max of 300 mg daily).

Criteria for Starting: ARV 1st Line Regimen:

Children < 3 years

All HIV infected children with active TB disease should begin TB treatment immediately, and start ART as soon as ATT is tolerated in the first 2-8 weeks of TB therapy, irrespective of the CD4 count and clinical stage.

Infant and Children with TB co-infection:

Preferred:

- AZT + 3TC + ABC

Alternative:

- AZT + 3TC + NVP

Children diagnosed with TB while on first line ARV regimen:

For children under 3 years maximize dose of NVP to 200mg/m2 or give a triple NRTI regimen (AZT/3TC/ABC)

Children ≥ 3 years

Infant and Children with TB co-infection:

Preferred:

- AZT + 3TC + EFV

Alternative:

- ABC + 3TC + EFVChildren diagnosed with TB while on first line ARV regimen:

For children 3 years and older who are NVP based regimen, it should be substituted with EFV. For patients on a regimen containing LPV/r, adjust RTV dose to LPV: RTV ratio of 1:1.
